PRINTED: 05/30/2012 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION (X3) DATE S COMPLE		
		157113	B. WIN	G		03/2	8/2012
	OVIDER OR SUPPLIER		•	30	EET ADDRESS, CITY, STATE, ZIP CODE 00 N WASHINGTON RAWFORDSVILLE, IN 47933	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS		G	000			
	This visit was a home recertification survey survey.	e health federal that resulted in an extended					
	Survey dates: March Partially extended date:	•					
	Facility #005304						
	Medicaid Vendor: # 1	100263820A					
	leader Dawn Snider, RN	oston, RN, PHNS - team N, PHNS - team member N, PHNS - team member					
	Previous years Census Skilled: 638 Home Health Only: Personal Care Only: Total: 687	3 29 14					
	Sample: Record review with a Record review with or Total record reviews:	ut a home visit: 7					
	Quality Review: Joyco April 5, 2012	e Elder, MSN, BSN, RN 2					
G 108	5/23/12. je	ified as the result of an IDR	G	108			
	PARTICIPATE	SUPPLIER REPRESENTATIVE'S SIGNATURE		-	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: IN005304

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF	
		157113	B. WIN	G		03/2	8/2012
	OVIDER OR SUPPLIER		•	30	EET ADDRESS, CITY, STATE, ZIP CODE 00 N WASHINGTON RAWFORDSVILLE, IN 47933		
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G 108	any changes in the care The HHA must advise the disciplines that wi frequency of visits proof the HHA must advise any change in the plais made.	ght to be informed, in ire to be furnished, and of	G	108			
G 113	failed to ensure the p frequency of visits an for 1 of 12 records re Findings include: Clinical record #12, s include documentatio informed of the freque be furnished. 484.10(e)(1) PATIEN The patient has the ri care is initiated, of the for the HHA services Medicare or other so which payment may be This STANDARD is r	ord review, the agency atient was informed of the d the care to be furnished viewed (#12). tart of care 12/5/11, failed to n the patient had been ency of visits or the care to T LIABILITY FOR PAYMENT ght to be advised, before extent to which payment may be expected from arces, and the extent to be required from the patient.	G	113			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		PLE CONSTRUCTION	(X3) DATE SUR COMPLETI	
		157113	B. WIN	G_		03/28	8/2012
	ROVIDER OR SUPPLIER		•	3	REET ADDRESS, CITY, STATE, ZIP CODE 00 N WASHINGTON CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 113	and policy review and to ensure the patient to services, of the popayment may be required accumentation was sfor 10 (#s 1, 2, 3, 4, 5 clinical records review received services from Crawfordsville and wafter 05/06/09. Findings include: 1. Clinical record rew 7/15/11, failed to evice informed of any potential the services. The administrated titled "Home Care Cosigned by the patient evidence the patient potential charges that required to pay for the provided. 2. Clinical record rew to evidence the patient potential charges for The administrated titled "Home Care Cosigned by the patient evidence the patient potential charges for the patient evidence the patient potential charges that	d interview, the agency failed was clearly informed, prior tential extent to which dired from the patient and tored in the clinical record in the clinical record in the clinical record in the patients which must be patients which must be parent site in the parent site in the parent site in the parent site in the patient was not all charges for the home for evidenced a document everage dated 7/15/11 and in the patient might be the home health services the patient might be the home health services the patient might be the home health services. The document failed to the agency of the patient might be the home health services the patient might be the home health services. The document of any the home health services the patient might be the home health services. The document failed to was informed of any the home for any the home health services was informed of any the home health services.	G	113			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		157113	B. WIN	IG		03/2	8/2012
	OVIDER OR SUPPLIER		.	3	REET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON CRAWFORDSVILLE, IN 47933	,	<i></i>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 113	3. Clinical record rev to evidence the patient potential charges for The administrator titled "Home Care Co signed by the patient potential charges that required to pay for the provided. 4. Clinical record 4, Sevidence the patient oppotential charges for The administrator titled "Home Care Co signed by the patient evidence the patient oppotential charges that required to pay for the provided. 5. Clinical record # 5 evidence the patient oppotential charges for The administrator titled "Home Care Co signed by the patient oppotential charges for The administrator titled "Home Care Co signed by the patient oppotential charges that required to pay for the potential charges that required to pay for the provided.	iew # 3, SOC 12/9/09, failed at was informed of any the home health services. If evidenced a document verage" dated 12/09/09 and The document failed to was informed of any the patient might be thome health services. SOC 3/19/12, failed to was informed of any the home health services. If evidenced a document verage" dated 3/19/12 and The document failed to was informed of any the patient might be thome health services. If evidenced a document verage home health services. If evidenced a document verage home health services. If evidenced a document verage dated 3/19/12 and The document failed to was informed of any the home health services. If evidenced a document verage dated 3/19/12 and The document failed to was informed of any the patient might be the home health services.	G	113			

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G 113	potential charges for The administrator titled "Home Care Cosigned by the patient evidence the patient potential charges that required to pay for the provided. 7. Clinical record # 8 evidence the patient potential charges for The administrator titled "Home Care Cosigned by the patient evidence the patient potential charges that required to pay for the provided. 8. Clinical record # 9 evidence the patient potential charges for The administrator titled "Home Care Cosigned by the patient potential charges for The administrator titled "Home Care Cosigned by the patient evidence the patient evidence the patient evidence the patient evidence the patient potential charges that required to pay for the provided. 9. Clinical record # 1 evidence the patient	the home health services. or evidenced a document overage" dated 3/19/12 and	G	113			

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G 113	titled "Home Care Co signed by the patient potential charges that required to pay for the provided. 10. Clinical record # evidence the patient potential charges for The administrato titled "Home Care Co signed by the patient potential charges that required to pay for the potential charges that required to pay for the provided. 11. On 3/27/12 at 3:1 indicated evidence papotential cost was nown She indicated the inforceord which was in the Greencastle branch. 12. On March 27, 20 administrator delivered "Home Care Coverages ite, patients 1, 2, 3, 4 indicated the docume billing department local Indiana branch. The fax number, dated 3/2 15:18 across the top of the patients of the	r evidenced a document verage" dated 10/18/11 and The document failed to was informed of any the patient might be home health services. 13, SOC 3/12/12, failed to was informed of any the home health services. r evidenced a document verage" dated 3/12/12 and The document failed to was informed of any the patient might be home health services. 3 PM, the administrator attents were informed of the kept in the clinical record. Formation was kept in a billing the billing office located at ch of the agency. 12, at 4 PM, the add 10 documents titled the for patients of the parent 4, 5, 7, 8, 9, 10, and 13. She ents were faxed from the ated in the Greencastle documents evidenced the 27/2012, and the time of	G	113			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		ONSTRUCTION	(X3) DATE SUI COMPLET	
		157113	B. WING			03/2	28/2012
	OVIDER OR SUPPLIER	10000		300 N	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON VFORDSVILLE, IN 47933	03/2	.0/2012
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	initial evaluation / ass professional 3.3.2 the patient and his / h the initiation of care financial agreement, and the initiation of care financial agreement, and the initiation of care financial agreement, and the patient agreement, and the extense coverage patient about the extense services may be a Medicaid, or any other known to the agency that will not be covered that the patient may hadmitting professional and files it in the clinic 484.10(e)(1(i-iii)) PATI PAYMENT Before the care is initiate patient, or ally and (i) The extent to which from Medicare, Medicare, Medicare dii) The charges for secovered by Medicare (iii) The charges that pay. This STANDARD is a Based on admission and policy review and to ensure the patient to services, of the positive services, of the positive services and the patient to services, of the positive services and the patient to services, of the positive services and the patient to services, of the positive services and the patient to services, of the positive services and the patient to services, of the positive services and the patient to services, of the positive services and the patient to services, of the positive services and the patient to services.	Procedure 3.3 during the sessment, the admitting 2 Presents and explains to her representative, before 3.3.2.2 Service or any financial liability." May 206 titled "Patient provides the patient with agreement and informs the ent to which payment for his / expected from Medicare / er federally funded program . The charges for services ed by Medicare. Charges have to pay The al signs and dates the form cal record." IENT LIABILITY FOR tiated, the HHA must inform d in writing, of: h payment may be expected caid, or any other Federally ram known to the HHA; ervices that will not be		1113			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPL	
		157113	B. WING _		03	/28/2012
	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 114	for 10 (#s 1, 2, 3, 4, clinical records revier received services for Crawfordsville and vafter 05/06/09. Findings include: 1. Clinical record re 7/15/11, failed to evinformed of any potential the services. The administratitled "Home Care Cosigned by the patient evidence the patient potential charges the required to pay for the potential charges for the administratitled "Home Care Cosigned by the patient potential charges for the administratitled "Home Care Cosigned by the patient evidence the patient potential charges the required to pay for the potential charges the required to pay for the provided. 3. Clinical record responsive to evidence the patient potential charges the required to pay for the provided.	stored in the clinical record 5, 7, 8, 9, 10, and 13) of 10 ewed of patients which om the parent site in vere admitted to the agency eview # 1, start of care (SOC) dence the patient was ential charges for the home everage dated 7/15/11 and at. The document failed to a was informed of any at the patient might be the home health services eview # 2, SOC 9/13/11, failed ent was informed of any at the home health services. For evidenced a document overage dated 9/13/11 and at. The document failed to a was informed of any at the home health services. For evidenced a document overage dated 9/13/11 and at. The document failed to a was informed of any at the patient might be the home health services.	G 114	4		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SUF COMPLET	
		157113	B. WIN	G		03/2	8/2012
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G 114	titled "Home Care Coming and by the patient evidence the patient potential charges that required to pay for the provided. 4. Clinical record 4, evidence the patient potential charges for The administration titled "Home Care Coming and by the patient evidence the patient potential charges that required to pay for the provided. 5. Clinical record # sevidence the patient potential charges for The administration titled "Home Care Coming and by the patient potential charges for the potential charges that required to pay for the provided. 6. Clinical record # sevidence the patient potential charges for The administration potential charges for The administration that potential charges for The administration that the patient potential charges for The administration	or evidenced a document overage" dated 12/09/09 and to the patient might be the home health services. SOC 3/19/12, failed to was informed of any the home health services. The document failed to was informed of any the home health services. The document failed to was informed of any the patient might be the home health services. SOC 3/19/12, failed to was informed of any the home health services. SOC 3/19/12, failed to was informed of any the home health services. The document failed to was informed of any the home health services. The document failed to was informed of any the home health services. The document failed to was informed of any the home health services. The document failed to was informed of any the home health services. The document failed to was informed of any the home health services. The document failed to was informed of any the home health services.	G	114			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPL	
		157113	B. WING _		03	/28/2012
	ROVIDER OR SUPPLIER	•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON CRAWFORDSVILLE, IN 47933	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 114	evidence the patient potential charges that required to pay for the provided. 7. Clinical record # evidence the patient potential charges for The administrat titled "Home Care C signed by the patient evidence the patient potential charges that required to pay for the provided. 8. Clinical record # evidence the patient potential charges for The administrat titled "Home Care C signed by the patient evidence the patient potential charges for evidence the patient potential charges that required to pay for the potential charges that required to pay for the potential charges for the administrat titled "Home Care C signed by the patient potential charges for The administrat titled "Home Care C signed by the patient potential charges for the patient potential charges for the administrat titled "Home Care C signed by the patient potential charges for	t. The document failed to was informed of any at the patient might be he home health services 8, SOC 11/18/11, failed to was informed of any the home health services. or evidenced a document overage" dated 11/18/11 and t. The document failed to was informed of any at the patient might be he home health services. 9, SOC 11/21/11, failed to was informed of any the home health services. or evidenced a document overage" dated 11/21/11 and t. The document failed to was informed of any the home health services. or evidenced a document overage" dated 11/21/11 and t. The document failed to was informed of any at the patient might be he home health services. 10, SOC 10/18/11, failed to was informed of any the home health services. or evidenced a document overage" dated 10/18/11 and t. The document failed to was informed of any the home health services.	G 11	4		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
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	OVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON CRAWFORDSVILLE, IN 47933	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 114	potential charges that required to pay for the provided. 10. Clinical record # evidence the patient of potential charges for the potential charges for the potential charges for the potential charges that required to pay for the provided. 11. On 3/27/12 at 3:1 indicated evidence pay for the provided. 11. On 3/27/12 at 3:1 indicated evidence pay for the provided. 12. On March 27, 20 administrator delivered "Home Care Coverages ite, patients 1, 2, 3, 4 indicated the docume billing department local Indiana branch. The fax number, dated 3/2 15:18 across the top of 13. The policy dated stated, "3.0 Policy / Pinitial evaluation / ass professional 3.3.2	the patient might be home health services 13, SOC 3/12/12, failed to was informed of any the home health services. It evidenced a document verage" dated 3/12/12 and The document failed to was informed of any the patient might be home health services 3 PM, the administrator stients were informed of the takept in the clinical record. In the billing office located at ch of the agency. 12, at 4 PM, the did 10 documents titled e" for patients of the parent 4, 5, 7, 8, 9, 10, and 13. She into were faxed from the ated in the Greencastle documents evidenced the 27/2012, and the time of	G	114			

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G 114	Rights" stated, "3.2.2 home care coverage patient about the extent her services may be a Medicaid, or any other known to the agency. That will not be covered that the patient may hadmitting professional and files it in the clinical 484.12(c) COMPLIAN PROFESSIONAL STITCH HHA and its staff professional standard to professional standard to professional furnish This STANDARD is reprovided services in a control policies and provided services in a control policies and professional standard to prof	May 2006 titled "Patient provides the patient with agreement and informs the ent to which payment for his / expected from Medicare / or federally funded program. The charges for services ed by Medicare. Charges have to pay The I signs and dates the form cal record." ICE W/ ACCEPTED ICE W/ ACCEPTED In must comply with accepted as and principles that apply shing services in an HHA. Into t met as evidenced by: In, interview, and review of ed to ensure employees accordance with infection rocedures for the Centers Standard Precautions" in 2 of 2 skilled nurse visits a potential for the transfer of		114			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		()	ULTIPLE LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		157113	B. WIN	IG		03/2	8/2012
	ROVIDER OR SUPPLIER		1	300	T ADDRESS, CITY, STATE, ZIP CODE N WASHINGTON AWFORDSVILLE, IN 47933		-
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G 121	Isolation Precautions of Infectious Agents i states, "IV. Standard Hygiene. During the unnecessary touching proximity to the patie contamination of cleasurfaces and transmi contaminated hands Perform hand hygien contact with excretio. IV.A.3.d. If hands we contaminated body significantly during patient care." 2. During home visit employee H was obsto patient #1. While wound care, she placed directly onto the patient barrier and when she picked up the supplier not a clean environm. 3. During a home visit employee A was observanced in the cuff and zippered bag without She then was observanced in the was observanc	isease Control "Guideline for Preventing Transmission Healthcare Settings 2007" Precautions IV.A. Hand delivery of healthcare, avoid g of surfaces in close in to prevent both in hands from environmental sision of pathogens from to surfaces IV.A.3. e IV.A.3.b. After ins, mucous membranes, will be moving from a site to a clean body site. on 3/23/12 at 4 PM, erved to provide wound care preparing the supplies for sed the unopened supplies ent's bedspread without a performed wound care, she is from the bed spread and ent. sit on 3/26/12 at 3 PM, erved to assess patient # 7, ary artery bypass graft imployee A assessed the ure and pulse, then she stethoscope to a black decontaminating the items. ed to palpate and touch the bare hands. She had not hands prior to touching the	G	121			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 121	indicated all the staff proper infection control the staff were to use a tools before placing the in the case of gross of keep the soiled suppled decontaminate before She also indicated all between their visit barenvironment. She also visits are conducted the control practices of the the evidence to substant the evidence to substant the evidence to substant the preflects compliance with staff and supervision of Policy dated A and Supervision of Policy dated A and Supervision of Policy dated A and Supervision and state Applicable federal, stagency ensures that a competent and proficion duties." 6. The policy dated A Control stated, "The director of clinical send developing, implement infection control progression with requirements Centers for Disease C Prevention's guideline with staff and with pastorage of equipment 484.14 ORGANIZATI	S PM, the administrator have been educated on ol practices. She indicated alcohol wipes to clean their nem into their visit bag and contamination, they were to it is separate from clean and e use on another patient. It is taff are to place a barrier g and the patients is o indicated supervisory of monitor the infection reir staff but she did not have antiate the monitoring. May 2003 titled "Competency resonnel" stated, "Purposes practice of other personnel with 1.1.1 the professional in the conditions of the Practice Acts. 1.1.2 reate., and local laws The the other personnel are itent to perform the assigned signal and monitoring the ram, to ensure compliance. The agency uses the Control (CDC) and the serior of infection tient care. Cleaning and and supplies."		121			
	ADMINISTRATION						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		_D BE	(X5) COMPLETION DATE			
G 123	control, and lines of a	s furnished, administrative uthority for the delegation of the patient care level are	G	123			
	Based on interview a documents, the ager organizational chart is providing services for branches were include chart reviewed with the agency's patients.	ncy failed to ensure the					
	evidence the home h Greencastle and Roo 2. On March 22, 201 administrator indicate was not an active site the building but there 3. On March 26, 201 administrator indicate manager at the Gree she and her alternate one of them is preser	2, at 1:55 PM, the det the branch in Rockville e. She indicated staff use was not an active branch. 2, at 9:15 AM, the desired she did not have a branch incastle site. She indicated administrator rotate and					

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		157113	B. WING _		03/28/2012	
	OVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 123	Continued From page 4. On March 28, 201	2, at 4:45 PM, the	G 12:	3		
G 158	person that ran the da primary site, and the a ran the Greencastle b operations. She indic the week and sometim	ated they rotate through out	G 158	3		
		plan of care established wed by a doctor of medicine, ric medicine.				
	Based on policy and observation, and interensure the care proviphysician ordered pla active clinical records orders for home healt	not met as evidenced by: clinical record review, rview, the agency failed to ded to the patient followed a n of care in 1 of 5 (patient 9) reviewed of patients with h aide services creating the t omission and patient harm ts of the agency.				
	Findings include:					
	through 5/18/12 with a visit every 2 weeks to catheter. The plan of size catheter to be us A. During a hom	e established by the fication period 3/20/12 orders for a skilled nurse change a supra - pubic care failed to evidence the ed for each change. e visit on 3/27/12 at 10:30				
	_	e visit on 3/27/12 at 10:30 oserved in a hospital bed				

		X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		157113	B. WIN	3		03/2	8/2012
	ROVIDER OR SUPPLIER		·	300	ET ADDRESS, CITY, STATE, ZIP CODE D N WASHINGTON RAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 158	with half side rails up alternating low air los electric Hoyer lift, an shower chair, and an Employee E, a home used the electric Hoy move the patient from wheelchair and to the caregiver with the patthe shower chair ever patient. She indicate home for months, app November of 2011. Ethat, at times, she ampatient, one arm and patient to the therapy Employee E indicated patient. Only the patifeedings. Employee oral care every mornicare provided by her produced pink oral sy She indicated she dipliquid and then places allow the patient to stated, "It says to spit." E then read the back stated, "It says to spit." B. The plan of c to evidence orders fo on the hospital bed; 2 transfers between su shower chair; 4) an o lift by means of a 2 m individual; and 5) the any exercise program.	on both sides of the bed, an a mattress on the bed, an electric wheelchair, a elevated therapy mat. health aide, indicated she er lift every other day, to a the bed to the electric therapy mat to assist the itent's exercises and utilized by other day for bathing the did the Hoyer had been in the proximately October or employee E also indicated did the caregiver pick up the one leg each and carry the mat for exercises. If she has never fed the ent's caregiver provides oral E indicated she performs ing. She described the oral for this patient. She wabs and a bottle of Biotene. It is a swab into the Biotene is it in the patient's mouth to lick the liquid from the swab. She swallows it." Employee of the bottle out loud and out." The beginning 3/20/12 failed in 1) the use of the Hoyer for faces; 3) the use of a rider for the aide to physically	G	158			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		157113	B. WING		03/28/2012	
	OVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP CODE 100 N WASHINGTON CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 158	how often to be perforurse. C. The plan of compatient was on a regular comprehensive assess the patient was "NPO swallowing difficulties." 2. The policy dated Mof Personnel" stated, or personal care atter registered nurse evaluand plan of care therapist prepares wr. 3. The policy dated A Service" stated, "The health aide services registered nurse and of care." 484.18(a) PLAN OF COMMENT The plan of care development and the agency staff cover including mental state equipment required, for prognosis, rehabilitatil limitations, activities prequirements, medical safety measures to prognosity of timely any other appropriate.	rindividual, the location, rmed, and when to notify the are dated 3/20/12 stated the alar diet. The asment dated 3/15/12 stated and with "chewing / and and services, the uates the patient's needs The registered nurse or agency provides home are under the supervision of a in accordance with the plan CARE Beloped in consultation with re all pertinent diagnoses, as, types of services and arequency of visits, on potential, functional permitted, nutritional ations and treatments, any rotect against injury, discharge or referral, and	G 158			
		n, interview, and clinical				

Facility ID: IN005304

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		157113	B. WIN	G		03/2	8/2012
	OVIDER OR SUPPLIER		•	30	EET ADDRESS, CITY, STATE, ZIP CODE 00 N WASHINGTON RAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
G 159	failed to ensure all paper plan of care that inclue elementsfor 2 (# 9 and records reviewed of phealth aide services, treatment omission and patients of the agency. The findings include: 1. Clinical record #9, included a plan of care physician for the certithrough 5/18/12 with evisit every 2 weeks to catheter. The plan of size catheter to be used. A. During a homous AM, patient #9 was on with half side rails upunalternating low air lose electric Hoyer lift, and shower chair, and an Employee E, a home used the electric Hoyer wheelchair and to the caregiver with the patithe shower chair every patient. She indicate home for months, approximation, one arm and patient to the therapy.	start of care 11/21/11 e established by the fication period 3/20/12 orders for a skilled nurse change a supra - pubic care failed to evidence the ed for each change. e visit on 3/27/12 at 10:30 observed in a hospital bed on both sides of the bed, an electric wheelchair, a elevated therapy mat. health aide, indicated she er lift every other day, to a the bed to the electric therapy mat to assist the ient's exercises and utilized by other day for bathing the d the Hoyer had been in the oroximately October or employee E also indicated d the caregiver pick up the one leg each and carry the	G	159			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		157113	B. WIN	G		03/2	8/2012
	OVIDER OR SUPPLIER		•	30	EET ADDRESS, CITY, STATE, ZIP CODE 0 N WASHINGTON RAWFORDSVILLE, IN 47933	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 159	patient. Only the patifeedings. Employee oral care every mornicare provided by her produced pink oral sw. She indicated she dipliquid and then places allow the patient to sw. The employee said, "E then read the back stated, "It says to spit. B. The plan of coto evidence orders for on the hospital bed; 2 transfers between swishower chair; 4) an olift by means of a 2 m individual; and 5) the any exercise program active or passive, individual; and sistance of another how often to be performance. C. The plan of copatient was on a regular comprehensive assess the patient was on a regular comprehensive assess the patient was "NPO swallowing difficulties." 2. The policy dated for personnel stated, or personal care atter registered nurse eval	ent's caregiver provides oral E indicated she performs ng. She described the oral for this patient. She wabs and a bottle of Biotene. It is a swab into the Biotene is it in the patient's mouth to lick the liquid from the swab. She swallows it." Employee of the bottle out loud and rout." The beginning 3/20/12 failed or 1) the use of half side rails or the use of the Hoyer for faces; 3) the use of a rider for the aide to physically an transfer with any aide to perform or assist or the type of exercises ependent or only with the rindividual, the location, rmed, and when to notify the lar diet. The sament dated 3/20/12 stated the lar diet. The sament dated 3/15/12 stated "and with "chewing /" May 2003 titled "Assignment "For home health aide and / indant services, the lates the patient's needs The registered nurse or	G	159			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		157113	B. WIN	G		03/28/2012	
	OVIDER OR SUPPLIER		·	300 N \	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON VFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 159	3. The policy dated A Service" stated, "The health aide services . registered nurse and of care." 4. Clinical record #11 the certification perior failed to evidence the and a personal life ale were observed in the 1:30 PM. The physic patient to the bathroo The patient was obse system. 484.30(a) DUTIES Of NURSE The registered nurse preventative and rehapprocedures. This STANDARD is represented the agency registered nurse initial and rehabilitative providentified on the compost of 5 active clinical recompost for home health aide potential for treatmenter for all the patients of the services.	april 2004 titled "Scope of agency provides home under the supervision of a in accordance with the plan included a plan of care for ad of 3/19/12-5/17/12 that patient had a rolling walker ent system. These items patient's home 3/26/12 at all therapist wasked to the musing the rolling walker. The REGISTERED initiates appropriate abilitative nursing the dependence of and policy review and failed to ensure the steed appropriate preventative cedures for the patient risks orehensive assessment in 2 cords reviewed with orders services, creating the tomission and patient harm the agency.		175			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		157113	B. WIN	G		03/2	8/2012
	OVIDER OR SUPPLIER			30	EET ADDRESS, CITY, STATE, ZIP CODE 0 N WASHINGTON RAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 175	patient was homebour poor balance. The codated 3/23/12, compliant the patient was a dated 11/29/11 through for skilled nurse visits stated, "to assess saft implement a falls part of assess safety of himplement a falls previous patient transfer in and provide bathing assist for assistance as turn commode to the tub. Out of the tub, the patient was without any and grab bars in the barnot use a gait belt who during the transfers. D. The document a fall complement to the patient to sit of tub was without any and grab bars in the barnot use a gait belt who during the transfers.	24/12 completed by sessment indicated that the and due to unsteady gait and omprehensive assessment eted by employee H, ent was homebound due to or balance and needed g. are for the certification period of 1/27/12 included orders every other week and ety of home environment. The revention program." are for the certification period of 3/27/12 included orders for ery other week and stated, ome environment.	G	175			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		157113	B. WING		03/:	28/2012
	OVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 175	addressed the identibalance. E. On 3/28/12 evidenced a case or 8/9/11 that stated, "S during conference a bathroom, family do on shower seat, grainformed SW [social administration] about was no further informed. Clinical record #S included a plan of case which state, "HHA [I with personal care a up to 8 hours Monda. A. During a hound A. During a houn	at 4:45 PM, the administrator or o	G 175			
		nd the caregiver pick up the done leg each and carry the y mat for exercises.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		157113	B. WING	<u> </u>	03	/28/2012
	OVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO 300 N WASHINGTON CRAWFORDSVILLE, IN 47933	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO) DEFICIENCY	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 175	patient. Only the patiented feedings. Employee oral care every more care provided by help produced pink oral significant of the state of the patient to significant of the state of the sta	and she has never fed the stient's caregiver provides oral of E indicated she performs aring. She described the oral of for this patient. She wabs and a bottle of Biotene. It is is it in the patient's mouth to suck the liquid from the swab. The swallows it. Employee to of the bottle out loud and it out. The use of half side rails 2) the use of the Hoyer for curfaces; 3) the use of a border for the aide to physically man transfer with any of eaide to perform or assist on, the type of exercises dependent or only with the er individual, the location, formed, and when to notify the care dated 3/20/12 stated the ular diet. The essment dated 3/15/12 stated D" and with "chewing /	G 1	175		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	BUILDING COMF WING 0 STREET ADDRESS, CITY, STATE, ZIP CODE		(X3) DATE SUF COMPLET	OATE SURVEY OMPLETED	
		157113	B. WIN	G		03/2	8/2012	
	OVIDER OR SUPPLIER			30	EET ADDRESS, CITY, STATE, ZIP CODE 10 N WASHINGTON RAWFORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
G 175	injury to the patient are evidenced instruction serve meals" to the N patient. The assignment instruction for the use to offer it to the patient swallowing. 3. The policy dated N of Personnel" stated, or personal care atter registered nurse evaluand plan of care therapist prepares wr 4. The policy dated A Service" stated, "The health aide services registered nurse and of care." 484.36(c)(1) ASSIGN HOME HEALTH AIDE Written patient care in health aide must be purse or other appropresponsible for the such health aide under part This STANDARD is repared to policy and observation, and interensure the registered health aide with adequive the such aide with adequive means the registered health aide with adequive the registered health aide with adequiversal to the reg	and staff. The assignment for the aide to "prepare and PO [nothing by mouth] ent failed to evidence of Biotene and for the aide at for the purpose of May 2003 titled "Assignment "For home health aide and / indant services, the patient's needs the patient's needs The registered nurse or litten instructions." April 2004 titled "Scope of agency provides home are under the supervision of a in accordance with the plan in accordance with the plan metals by the registered wriate professional who is pervision of the home agraph (d) of this section. The tot met as evidenced by: clinical record review, roiew, the agency failed to nurse provided the home uate and correct written		224				
	aide services and the	ovision of the home health services provided were ian for 1 (9) of 5 active						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		157113	B. WIN	G		03/2	8/2012
	ROVIDER OR SUPPLIER		•	3	REET ADDRESS, CITY, STATE, ZIP CODE 00 N WASHINGTON CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 224	health aide services, harm or imminent throagency services. The findings include: 1. Clinical record #9, included a plan of car which state, "HHA [howith personal care an up to 8 hours Monday A. During a hom AM, patient #9 was o with half side rails up alternating low air los electric hoyer lift, and chair, and an elevate E, a home health aide electric hoyer lift ever patient from the bed thank to the therapy mathe patient's exercise chair every other day indicated the hoyer honths, approximate 2011. Employee E alshe and the caregive arm and one leg each therapy mat for exercise she has never fed the caregiver provides or indicated she perform She described the orathis patient. She proabottle of Biotene.	ved with orders for home creating the potential for eat to all patients receiving start of care 11/21/11, re dated 3/20/12 with orders ome health aide] to assist d transfers. Visits may last	G	224			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		157113	B. WIN	G_		03/2	8/2012
	OVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON CRAWFORDSVILLE, IN 47933	,	<i></i>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 224	the patient's mouth to the liquid from the sw "She swallows it." Er back of the bottle out spit out." B. The plan of comparison to evidence orders for on the hospital bed; 20 transfers between sure shower chair; 4) and of lift by means of a 2 m individual; and 5) the any exercise program active or passive, individual; and 5) the any exercise program active or passive, individuals and how often to be performance. C. The plan of comparison to be performance. C. The plan of comparison to be performance. D. The HHA assisted to 5/18/12 failed to extransferring the patient means to be used, mindividuals and how mandered instruction serve meals" to the Nopatient. The assignment of the swallow mandered instruction serve meals to the Nopatient. The assignment of the swallow mandered instruction serve meals to the Nopatient. The assignment is to the Nopatient.	allow the patient to suck ab. The employee said, aployee E then read the loud and stated, "It says to are beginning 3/20/12 failed of 1) the use of half side rails of the use of the hoyer for faces; 3) the use of a reder for the aide to physically an transfer with any aide to perform or assist of the type of exercises rependent or only with the remark, and when to notify the lard diet. The sament dated 3/20/12 stated the lard diet. The sament dated 3/15/12 stated "and with "chewing /"." ignment sheet dated 3/20/12 idence any instruction for the between surfaces, the echanical or a lift by many, the frequency of the guidelines to prevent falls or and staff. The assignment for the aide to "prepare and PO [nothing by mouth] ent failed to evidence of Biotene and for the aide	G	224			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		157113	B. WIN	G		03/2	8/2012
	OVIDER OR SUPPLIER			30	EET ADDRESS, CITY, STATE, ZIP CODE 00 N WASHINGTON RAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
G 224	stated, "For home he	Assignment of Personnel" alth aide and / or personal	G	224			
	evaluates the patient' The registered nurse instructions."	es, the registered nurse s needs and plan of care or therapist prepares written					
G 225		e provides services that are	G	225			
		ian in the plan of care and tted to perform under state					
	Based on policy and observation, and interensure the home heat according to agency ply the physician for 1 clinical records review health aide services,	not met as evidenced by: clinical record review, rview, the agency failed to lth aide provided services colicy and that were ordered (patient # 9) of 5 active wed with orders for a home creating the potential for eceiving home health agency					
	The findings include:						
	included a plan of car which state, "HHA [ho	start of care 11/21/11, re dated 3/20/12 with orders ome health aide] to assist d transfers. Visits may last / through Friday."					
	_	e visit on 3/27/12 at 10:30 bserved in a hospital bed					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		157113	B. WIN	IG_		03/28	8/2012
	ROVIDER OR SUPPLIER		•	3	REET ADDRESS, CITY, STATE, ZIP CODE 100 N WASHINGTON CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
G 225	with half side rails up alternating low air los electric Hoyer lift, and shower chair, and an Employee E, a home used the electric Hoyer move the patient from wheelchair and to the caregiver with the pat the shower chair ever patient. She indicated home for months, app November of 2011. Ethat, at times, she and patient, one arm and patient to the therapy Employee E indicated patient. Only the patifeedings. Employee oral care every mornicare provided by her produced pink oral sw She indicated she dipliquid and then places allow the patient to su The employee said, "E then read the back stated, "It says to spit. B. The plan of coto evidence orders for on the hospital bed; 2 transfers between sur shower chair; 4) an or lift by means of a 2 m individual; and 5) the any exercise program.	on both sides of the bed, an a mattress on the bed, an electric wheelchair, a elevated therapy mat. health aide, indicated she er lift every other day, to a the bed to the electric therapy mat to assist the itent's exercises and utilized by other day for bathing the did the Hoyer had been in the proximately October or employee E also indicated did the caregiver pick up the one leg each and carry the mat for exercises. If she has never fed the ent's caregiver provides oral E indicated she performs ing. She described the oral for this patient. She wabs and a bottle of Biotene. It is a swab into the Biotene is it in the patient's mouth to lick the liquid from the swab. She swallows it." Employee of the bottle out loud and rout." The beginning 3/20/12 failed in 1) the use of half side rails and rother aide to physically or the aide to physically and rother aide to physically	G	225			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	ISTRUCTION (X3) DATE SUF COMPLETI	
		157113	B. WIN	G		03/2	8/2012
	OVIDER OR SUPPLIER			30	EET ADDRESS, CITY, STATE, ZIP CODE 10 N WASHINGTON RAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 225	how often to be perfornurse. C. The plan of creation was on a regure comprehensive assess the patient was "NPO swallowing difficulties. D. The HHA asset to 5/18/12 failed to extransferring the patient means to be used, mindividuals and how not transfers, any safety injury to the patient are evidenced instruction serve meals" to the Natient. The assignment	rindividual, the location, rmed, and when to notify the are dated 3/20/12 stated the lar diet. The sament dated 3/15/12 stated " and with "chewing / ." ignment sheet dated 3/20/12 ridence any instruction for at between surfaces, the	G	225			
G 337	stated, "For home hecare attendant service evaluates the patient" The registered nurse instructions." 484.55(c) DRUG REG The comprehensive a review of all medications in order to identeffects and drug reacting therapy, significations.	Assignment of Personnel" alth aide and / or personal es, the registered nurse s needs and plan of care or therapist prepares written	G	337			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE COMF	SURVEY PLETED
		157113	B. WING	3		3/28/2012
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 300 N WASHINGTON CRAWFORDSVILLE, II		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Based upon clinical interview, the agence comprehensive assers all the patient's medicare for 2 (patients 2 reviewed from the precertification for 6 (clinical records reviewed from the patients receiving from the patients receiving from the patients receiving from the patient reports and added from the patient reports and added from the patient records and the patients recorded from the patients and the patie	not met as evidenced by: record and policy review and y failed to ensure the essment included a review of ications at the at the start of 2 and 9) of 10 clinical records arent site and at # 1, 2, 3, 8, 9, and 10) of 10 ewed of patients from the cotential to affect all of the ng services from the agency. view # 1, start of care (SOC) dence a medication review I as part of the recertification essment for the certification essment for the certification visit on March 23, 2012, at 4 orted verbally he / she had any oral herbal remedies to a gime and had many inued since the SOC. view # 2, SOC 9/13/11, failed ation review had been I the start of care essment dated 9/13/11, yee K; the recertification essment dated 11/8/11, yee H; and the recertification essments dated 1/6/12 and	G 3	337		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		157113	B. WIN	G		03/2	8/2012
	OVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 100 N WASHINGTON CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 337	indicated the clinical remployees A, H, and of the patient's medic comprehensive assess. 3. Clinical record rev to evidence a medica completed as part of comprehensive assess completed by employ dated 1/24/12, completed by employee H. 4. Clinical record rev failed to evidence a m completed as part of comprehensive assess period beginning 1/17 5. Clinical record rev failed to evidence a m completed as part of comprehensive assess period beginning 1/17 5. Clinical record rev failed to evidence a m completed as part of comprehensive assess completed by employ dated 1/19/12, completed by employee H. 6. Clinical record rev failed to evidence a m completed as part of siled to evidence a m completed as par	12, at 2 PM, employee G record failed to evidence K, completed a total review ations as part of the ssment. iew # 3, SOC 12/9/09, failed tion review had been the recertification ssment dated 11/28/11, ee H; the reassessment eted by employee A; and the 3/23/12, completed by iew # 8, SOC 11/18/11, hedication review had been the recertification ssment for the certification 7/12 and 3/17/12. view # 9, SOC 11/21/11, hedication review had been the start of care ssment dated 11/21/11, hedication review had been the etart of care ssment dated 11/21/11, hedication review had been the start of care ssment dated 11/21/11, hedication review had been the recertification the H; the reassessment eted by employee G; and hed 3/15/12, completed by iew # 10, SOC 10/18/11, hedication review had been the recertification ssment for the certification	G	337	,		
	On 3/27/12 at 2:5	55 PM, employee G indicated					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	ULTIPL LDING	E CONSTRUCTION	(X3) DATE SUF COMPLET	
		157113		IG		03/2	8/2012
	OVIDER OR SUPPLIER			30	EET ADDRESS, CITY, STATE, ZIP CODE 0 N WASHINGTON RAWFORDSVILLE, IN 47933	00/2	0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 337	there was not evidentereview of all medications and potential reactions, including its significant side effect interactions, duplicate noncompliance with creassessments comp 2/10/12. 7. On March 28, 201 reviewing the electronal ternate administration ursing, she indicated does not prompt the amedication review areassessment; she in needs to check the boundary on the printer task and part of the creassessments. She the required task was knowledge and expensive using the softworderstood the required task was knowledge and expensive using the softworderstood the required task and part of the creassessments. She the required task was knowledge and expensive using the softworderstood the required task and part of the creassessments. She the required task was knowledge and expensive using the softworderstood the required task and part of the creassessments. She the required task was knowledge and expensive using the softworderstood the required task and part of the creassessments. She the required task was knowledge and expensive reasses. 8. The policy dated Medication / asseptions and a suppressional 3.3.2 medications the patie identify any potential drug reactions, significant significant in the patie identify any potential drug reactions, significant indications, including in the patient	ce in the clinical record of a cons the patient was using to adverse effects and drug neffective drug therapy, s, significant drug edrug therapy, and drug therapy for the eleted on 12/12/11 and eleted on 12	G	337			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION	(X3) DATE SUF	
		157113	B. WIN	IG		03/2	8/2012
	ROVIDER OR SUPPLIER		,	3	REET ADDRESS, CITY, STATE, ZIP CODE 00 N WASHINGTON CRAWFORDSVILLE, IN 47933	93.2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
G 337	9. The policy dated A stated, "3.2.2.3 Staff every 60 days and as assessment and an oregistered nurse and medications the patie ineffective drug thera reactions, significant	April 2004 titled "Medications" reviews medications at least s part of the comprehensive on going basis, The / or therapist assesses ent is taking to identify py, potential adverse side effects and drug ve drug therapy, and non	G	337			